



## SPECIAL IMC CONFERENCE SUMMARY ISSUE

The Industrial Medical Council concluded its second educational conference in November to favorable reviews by attendees. The conference, intended to educate treating physicians as to issues affecting their practice in the workers' compensation field, was attended by about 300 people.

We feel pretty good about our efforts," said Dr. Allan MacKenzie Executive Medical Director of the IMC. "Although it's difficult to cover so many areas in such a short period of time we believe that the attendees generally came away with a significant learning experience."

The conference covered such issues as apportionment, the role of the primary treating physician, disability rating, new case law affecting physicians and a variety of other issues treaters are faced with in their workers compensation practice.

Questions and Answers arising from the conference discussions were forwarded to presenters and appear in this issue of the newsletter beginning on page 2.

The IMC is offering a complete set of audio tapes of both IMC Educational Conferences for physicians and to those interested in purchasing them for home or office use. The tapes cover the full conferences. The price is \$25.00 per conference and includes a copy of the syllabus. Call 1-800-794-6900 to order.

## Council Addresses Long Term Goals at Public Session

At its December monthly meeting the IMC held public discussions about its long range plans and concerns for the future affecting both the Council and the workers' compensation community generally. The meeting yielded several excellent suggestions and will provide a basis for future Council activities and regulatory work.

*The following are some highlights from the public's discussion and Council member's individual comments:*

**Dr. Clayton E. Pachett, member of the California Medical Assn:**

❖ The IMC should define a quality care commitment to injured workers by:

a) Conducting more research on the treatment guidelines and by looking at research prospectively and defining quality care scientifically,

b) Ensure that other individuals taking care of the injured workers - nurse practitioners, physicians' assistants, and case managers are utilized in appropriate roles and within the scope of licensure as provided in state laws;

❖ Develop better QME training courses;

❖ Help reduce the "hassle factor" for the treating physicians. The hassles are too many, such as obtaining authorization for treatment which is time consuming. The simple disclosure act, a statement of non perjury, should not be necessary for treating physicians, but only for medical legal documents.

**Greg Vach, Commission on Health and Safety and Workers' Compensation (CHSWC):**

❖ The IMC should debate the whole

QME/AME/Treating Physician issue. It is his contention that there are approximately 10% QMEs who really know what they are doing;

❖ The IMC put on the agenda the issue of medical liens from fee schedule reductions. One way for the IMC to look at this is to provide guidelines to the judges;

❖ He also asked what the IMC would suggest as replacement for the HCO program. The HCO is supposed to work around problems by having internal peer review. Could there be a compromise by having clinics develop equivalent mechanisms?

**Dr. Ira Monosson M.D., IMC Council member:**

The IMC should establish a liaison committee between the IMC, the Judges, and the raters. He suggested that we formalize the relationship with the liaison committee consisting of a few IMC members and staff. The Council can get the judges and raters to increase the utilization of the IMC evaluation guidelines and to help us stimulate referrals of QME reports that are sub-standard and unratable. The Council could then try to do something about not punishing the physicians but getting them better educated.

**Dr. Peter Mandell, Chairman, California Orthopaedic Association (COA)**

❖ Find some way to get an earlier determination of AOE/COE issues among laborers and employees injured on the job. He hopes that the IMC could put together a committee to study and make recommendations to the legislature and

insurance industry on how to speed up the process and get a determination made at an earlier time.

❖ Many physicians are concerned about the QMEs' CME hours. The COA approach is to make a recommendation that the number of hours be reduced to at least 5 hours a year and to require that it be done every year. He added that they realized this would take legislative action but they hoped that if the IMC would get on board with this, it could perhaps be compelling on the legislature to make a change.

*Con't on p. 10*

### IMC Lowers QME Fees

At its December monthly meeting, the IMC voted to lower the fees QMEs are required to pay to maintain their QME status. Public hearings will be scheduled sometime in March and the new fee rates, when adopted, will be effective probably sometime this Summer.

The new schedule will divide fees into three tiers as opposed to the current two tiers. The proposal is as follows:

☛ 0-10 QMEs performed in one year = \$110 (56% reduction)

☛ 11-24 QMEs performed in one year = \$ 125 (50% reduction)

☛ More than 24 performed in one year - \$250 (50% reduction)

The fees are required by Labor Code §139.2 and fund various IMC studies and mandates.

## CONFERENCE

## Q&amp;A

**W**e received a large number of questions at the October Educational conference which we were unable to answer due to time constraints. The following are questions submitted to presenters for their response. Please note that the answers are not those of the IMC and express the presenters' point of view on a given area. These answers are not intended to serve as legal advice.

### Shirley James, Disability Evaluator

**Q:** Would you explain the difference between exacerbation of and/or aggravation of a pre-existing injury for rating purposes?

**A:** The DEU does not consider whether an injury is an aggravation or exacerbation of a previous injury in determining the overall level of permanent disability. The method of determining the permanent disability may be affected by an aggravation or exacerbation, and the overall level of permanent disability due to the industrial injury may change, but whether it is due to aggravation or exacerbation is not significant in the rating.

**Q:** When rating a workers' disability, do you consider only the work place or do you also consider (or want to hear about) their personal life?...e.g., pain precludes vacuuming or overhead dusting; pain precludes bicycling, skiing, kayaking...etc.

**A:** A disability in the overall market, including the current

work place, is what is considered. However, difficulty performing activities at home or elsewhere, should be translated by the physician into a work activity. For example, difficulty performing overhead dusting, can mean difficulty or inability to perform overhead work. Usually, if the injured worker has not returned to work, then his/her description of difficulties are based on activities they have either tried at home or attempted to complete various tasks at home. When the injured worker describes the activities in these terms, then the physician should try to describe the movements involved rather than the specific activity.

**Q:** Does "constant" pain contemplate a 24 hour day, or just the work day?

**A:** Constant pain refers to pain occurring approximately 85% to 100% of the "workday". Since a workday can be more than 8 hours, description of the pain should be based on what is occurring during the workday.

**Q:** Can you comment on "duplication of disability"? e.g. injured worker is given a permanent disability by an orthopedist - permanent disability by neurologist, permanent disability by an internist, permanent disability by a psychiatrist (usually all affiliated with a group of specialists seeing the injured worker within a short period of time).

**A:** When the permanent disability rating is determined the Disability Evaluator will take each report and consider whether or not the factors of disability, standing alone, in each report, further reduces the injured workers' ability to compete in the open labor market. An example would be a Neurologist precludes heavy lifting and an Internist precludes heavy lifting, repetitive lifting, and bending, in addition to precluding excessive emotional stress. The duplicating factors are based on whether or not the factors given in the Neurologist's report or the Internist's report further reduces the injured workers' overall ability to perform work activities. In this example, the preclusion from heavy lifting, defined as a 50% loss of pre-injury lifting capacity, duplicates with the heavy lifting part of the preclusion in the Internist's report. However, the preclusion from excessive emotional stress can result in an increased disability, thereby increasing the overall rating.

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### IMC Adds Two New Members

**Dr. Lawrence Tain, D.C.** has been reappointed by the Governor to a new four year term on the Industrial Medical Council. Dr. Tain has served on the Educational Committee and the Chiropractic Advisory Committee and has been instrumental in shaping the current IMC treatment guidelines.

**Dr. Paul Wakim, D.O.** has been appointed to fill Dr. Laurie Woll's position on the IMC. Dr. Wakim, an osteopathic surgeon practicing in Orange County has been a regular IMC meeting participant and was very involved in the recent fee schedule deliberations.

**Dr. Hubert Greenway, Jr. M.D.** has been appointed to fill Dr. Alicia Abels' position on the IMC. Dr. Greenway, a dermatologist, is chairman and a practicing physician for the Skin and Cosmetic Surgery Center at Scripps Clinic Medical Center in La Jolla.

The Council sends its heartfelt gratitude to both Dr. Woll and Dr. Abels for their selfless contributions during their terms on the Council and to issues affecting everyone in the workers' compensation community.

◆ *Con't from p. 2 - Shirley James*

**Q:** Explain percentage of time of subjective complaints: 25% -work time; 25% - awake time; 25% - of a 24 hour day?

A: Percentage of time referred to in the definition of subjective factors of disability refer to the percentage of time in a work day, it does not refer to awake time nor 24 hour day.

**Q:** Please clarify use of terms: Occasional, intermittent, etc. a. Does occasional mean up to 25% of the time or at least 25% of time but could include up to 40% of the day? b. Do the terms mean the same when used in the subjective complaints and work restrictions section?

A: When the DEU uses the percentages of time in describing subjective factors of disability, the margins are as follows: occasional = pain occurring from 15% to approximately 40% of the work day. If we use 8 hours as a theoretical work day, then pain would be occurring from 1.5 hours to 3.5 hours throughout the day; intermittent - 45% to approximately 70% of the workday. The term frequent has not been defined by the DEU but using the above as a reference, frequent can be defined as occurring more than 70% of the day but less than 90%.

**Q:** How does one obtain a revised schedule of permanent disability?

A: To obtain the revised Schedule for Rating Permanent Disabilities, telephone your local Workers' Compensation Appeals Board, and ask for the DEU. Request the post April, 1997 revised "Schedule for Rating Permanent Disabilities" from the DEU.

**Q:** Is it adequate to provide a quantified estimate of pre-injury function (such as a 25% loss of lifting strength) and an explicit restriction to a lifting limit in pounds or do we need to use a term such as "restricted to heavy lifting"?

A: It is preferable to describe the loss of pre-injury capacity in terms of percentages. Describing a loss of lifting ability in inability to lift an X number of pounds is not an adequate description of the loss without telling the Disability Evaluator how much the injured worker could lift before the injury.

**Q:** Since the upper extremity guidelines did not make it into the new schedule, what is the status of "work restrictions" and limitations regarding upper extremities?

A: A physician can describe permanent disability to any part of the body in terms of a work restriction. Work restrictions are not limited to the spine, neck, torso, and lower extremities. However, the work restriction should be appropriate for that particular part of the body. A work restriction such as "no repetitive finger motions for both hands" is entirely appropriate both to that part of the body and for purposes of describing the permanent disability.

**Q:** If the rater will only see the P & S report, does the history need to contain only the interval history since initially seen, or does the report need to be able to stand alone and include a review of the initial injury and all subsequent treatment?

A: The permanent and stationary report should stand alone. It should not make assumption, based on a prior report or reports, since the Disability Evaluator rates only the permanent and stationary report.

**Q:** A patient injures the upper extremities. He is complaining of problems with heavy lifting only. Is this Ratable? Is the restriction of no heavy lifting appropriate to upper extremities?

A: The upper extremities are important on performance of lifting activities. If an injured worker complains of pain on performance of this activity, or complains of an inability to perform this activity due to pain in the upper extremities, then

## Governor Davis Appoints New Director of Industrial Relations

Governor Gray Davis has appointed Mr. Steve Smith as the new Director of the Department of Industrial Relations. Mr. Smith, 44, has an extensive background in public sector labor relations, having spent over nine years as a government relations coordinator for the California State Employees Association, an organization that serves as the exclusive bargaining agent for 9 of the 21 units into which State of California rank and file (non-supervisory and non-managerial) employees are divided for collective bargaining purposes. Additionally, Mr. Smith served on Governor Davis' staff while Davis was Lieutenant Governor of California and was Governor Davis' Deputy Campaign Manager for Davis' gubernatorial general election campaign.

a preclusion from the activity is appropriate.

**Q:** Should we as physicians include a percentage of disability? Or leave that out of P & S referrals?

A: The major function of the Disability Evaluator is to take the physician's factors of disability and translate them into a percentage of permanent disability based on their expert knowledge of the Schedule for Rating Permanent Disabilities. The physician should not include a percentage of disability in the permanent and stationary report.

**Q:** When commenting on Jamar with incomplete effort, can we give % of less instead of actual expected (predicted) normal for that patient?

A: If a physician believes the injured worker is not giving maximum effort, then he/she should give what they believe is a reasonable loss of grasping power, based on the type of injury and their expertise in the area of recovery for these types of injuries.

**Q:** When listing objective findings, is pain with palpitation or pain with movement/ROM an objective finding?

A: Usually pain on palpitation is "tenderness" and only occurs on palpitation, so it is not considered a subjective factor of disability. Pain on range of motion, such as pain in the shoulder on raising the arm above shoulder level, is considered a subjective factor of disability.

**Q:** Should objective findings be limited to findings attributable to the injury? (i.e., degenerative finding or spine x-rays?)

A: Objective findings can include any finding during the physical examination, however, when giving the objective factors of disability the physician should limit these to those attributable to the injury. The findings not attributed to the injury should be given, but the physician should clearly state that these are not attributable to the injury.

**Q:** Are there established "norms" in preferring "grip tests"? The only one I know is Canadian Public Health.

A: There are no established estimated normal for loss of grasping power.

**Q:** Does the rater look only at the P & S report or are prior reports also used?

A: The Disability Evaluator only looks at the permanent and stationary medical report.

**Q:** How can a person be rated with a 30-35% permanent disability and be released back to regular work in prior job without any restrictions? Example : Back injury in warehouse workers.

*Con't on p. 5*



## Community Viewpoint

## The Presumption Problem

By: Arthur Johnson, Esq.

*Mr. Johnson is an applicant's attorney practicing in San Jose, California.*

We all know that pursuant to the Minnear case, the final report of the treating physician is "presumed correct" as to issues of permanent disability, future medical care, apportionment, etc. (see L.C. 4062.9)

However, there is a major problem with effectuating this presumption. The problem is that if an inadequate report is produced, then an inadequate result will occur, and yet be presumed correct. (See the recent case of Keulen v. WCAB (26 CWC, NO9, page 253), where the WCAB applied the presumption to a poorly written treating physician's report. On Appeal, the Court of Appeal found the QME report of applicant had "annihilated" the presumption.)

**The typical scenario that I see is as follows:**

The treating physician finds (often at the "prodding" of the carrier) that the claimant is permanent and stationary.

The treating doctor issues a final short form P & S report releasing the claimant from treatment, with virtually no description of final disability or its effects on the claimant's ability to work in the open labor market, and with virtually no thought given as to future medical care needs, particularly long term needs.

The physician bills \$50 or \$60 for a final treatment report, which the carrier pays. The carrier does not advise the physician that the treating physician is entitled to be paid \$400 for a final comprehensive treating physician Medical/Legal report.

In fact, if the physician requests authorization to prepare a final comprehensive Medical/Legal report and bill \$400 (the official authorized charge at 80% of QME rates), that authorization is most often either delayed or denied.

In truth, the carriers do not want a final comprehensive medical/legal report. The more information they obtain showing the actual disability and future medical care needs, the more likely they pay to resolve the case or the more reserves they will have to place on the case.

The carriers want the haphazard final check the box treatment report to be "presumed correct". On obtaining such a report, they calculate a minimum amount of P.D. and tell the claimant this has been determined by the treating doc-

tor, and is "presumed correct".

If a QME quality report is prepared anyway, then the carrier refuses to pay \$400 billing on the basis the report was "not requested" or "not authorized."

This is a very pervasive problem. It is definitely a problem for unrepresented workers, as they do not have sophisticated legal counsel who will secure the correct information so that a fair result may be obtained. The unrepresented claimant may be "stuck" with a hastily prepared final treatment report that the carrier now wants presumed correct, at a very unfavorable result for the claimant.

I have talked to many doctors regarding this problem. It is their universal experience that the carriers do not want to pay for medical/legal reports from the treating doctor because they do not want the treating doctor presumption effectively implemented by obtaining thorough information from them.

**Suggested Action**

It should not be the policy of the State of California to have inadequate reports presumed correct. It should instead be the policy of the State of California to require full and complete information in the final reports from treating doctors when those reports are going to be utilized as "presumptively correct" to finalize claims. Therefore, the following is proposed:

Upon receiving a final treatment report, the carriers shall notify the treating doctor that a final medical/legal report is required. Attached to that notice would

be a set of directions, on a format prepared by the IMC, as to what is required in a final medical/legal report of a treating physician.

The carrier shall be required to advise the treating doctor that he will be paid 80% of QME rates (\$400 for a basic report) upon receipt of the medical/legal report covering all of the issues set forth in this format.

If this was accomplished on a mandatory basis, we would see far fewer sloppily prepared final treatment reports. The treating doctors would have an incentive to prepare final medical/legal reports that were accurate and thorough. If the carrier had questions or issues that went beyond the format prepared by IMC, then the final comprehensive report could also address those matters. Potentially, the need for litigation would be reduced if treating doctors reports were more thorough and addressed all of the issues.

When the claimant asks for a panel and a QME report is prepared, the standard billing is \$500, and there are no quibbles by the carrier over the billing.

When the charge is \$100 or less for a comprehensive medical/legal report from a treating doctor, there should be no quibble over payment or delay over "authorization."

It is my hope that the IMC will immediately follow through on the suggestion contained in this article. It will benefit all injured workers and permit the treating doctors to perform their function fairly and appropriately and be paid for doing so.

## Patient Believability Factors - Part I

By: Michael Sackett, DC

*Dr. Sackett, practices in Hemet, CA.*

Under California regulations, subjective factors of disability are those that cannot be directly measured or observed. This could include pain and/or various forms of dysesthasias. The subjective factors of disability are the doctors' interpretation of the patients' interpretation of their pain. This may include pain at rest and/or with activity. The terms minimal, slight, moderate and severe pain have very specific meanings within the regulations and the wording can have major implications in the amount of disability that the injured worker is ultimately awarded.

In the treating physicians manual it

is mentioned that when evaluating pain the credibility of the injured worker must be carefully weighed. The purpose of this article is to deal with such credibility. In other words, is the injured workers interpretation of their own pain believable? Depending on the injured worker pain may be expressed in various ways. There are a variety of cultural differences in the way pain is expressed and experienced. It is important to take all of these factors into account when coming up with your own interpretation of the injured workers subjective complaints.

A physician performing a med/legal evaluation will often have only seen the patient one time. This makes it critical

*Con't on p. 11*

◆ *Con't from p. 3 - Shirley James*

A: Permanent disability ratings are based on many factors, and a work restriction is only one of the many factors. The rating can be based on the subjective factors, need for and use of a brace or an appliance, thigh and/or calf atrophy, limited motion, etc. So, an injured worker can be given significant permanent disability, but have no work restrictions, depending on the factors of disability used to determine the overall level of permanent disability.

**Q: How do we reflect "tenderness" or "muscle spasm" or subjective pain, numbness/weakness from pressure on a neck, coracoid process area - greater trochanter area. etc.?**

A: Tenderness, muscle spasms, numbness and weakness can be findings by the physician, but these findings are not ratable factors of disability. If these factors are significant, the physician should use these findings to determine if a work restriction is appropriate, or if they result in some limited motion. It is important to remember, the permanent disability rating assumes the factors, as given by the physician, result in some difficulty performing work activities. If the findings do not result in difficulty performing work activities, then it must be assumed the individual does not have permanent disability. The schedule for Rating Permanent Disabilities assumes certain factors of disability will lead to decreased work performance such as limited motion, atrophy, and use of braces or appliances. It also is a guide as to what physical findings should be considered ratable factors of disability.

**Q: Is a rating based on subjective or objective pain?**

A: Pain is considered, by the DEU, to be a subjective factor of disability. Limited motion is considered to be an objective factor of disability.

**Ted Blatt, MD**

**Q: A 45 year old male has a herniated disc L4-5 and refuses surgery, but wants to remain on disability. He feels surgery is too dangerous. What can you do? Refer him out? D/C your treatment, or comply with his demands?**

A: The patient can be made P & S, outlining his subjective & objective complaints, work restrictions & you can make provisions for future medical care.

**Q: Is the treating physician responsible or liable if the patient is returned to work and a similar injury or reoccurrence occurs?**

A: No.

**Q: As a General Surgeon a patient has post-op pain, a well healed incision and pain on palpation. Are a well healed incision and pain on palpation objective factors to be listed under factors of disability?**

A: Pain is a subjective factor. A scar is an objective factor.

**Q: How far into the future should you project future medical care?**

A: Whatever is required to relieve the effects of the work injury should be included regardless of any time element.

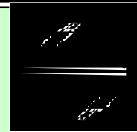
**Q: Isn't apportionment only an issue when there is disability due to a previous injury?**

A: It does not have to be an "injury" - it can be a pre-existing condition such as "arthritis".

**Q: Under future medical, can being too specific come back to hurt the patient? (i.e. many physicians have preferred tests, medications and new innovative diagnostics as meds are developed). Will your specificity curtail proper treatment?**

A: Not likely. "New procedures" that have replaced "old procedures" would very likely be appropriate.

**Q: If another party is seeking clarification from the PTP**



## on Demand

Telephone # (650)737-2063 or 1(800)794-6900 ext. 2063  
Forms and Course information for doctors press 1  
Forms for an injured worker press 2  
Agendas for IMC's monthly public meetings press 3  
For a list of approved guidelines press 4  
For IMC's Newsletter press 5  
To receive a directory of available faxes press 6  
To reach an operator press 0  
When calling from outside the 650 area code enter 1  
and your area code along with your fax number to receive a fax

**due to leaving info out of his report, either supplemental or final, can the PTP bill as med/legal? (Insurance carrier has not objected-only seeking more info, i.e. when do you anticipate the employee to become P & S?)**

A: Medical/legal applies only if requested as medical/legal by an attorney or insurance company.

**Q: a) When is P & S appropriate? If occasional symptoms require treatment?**

A: P & S means the patient is not likely to significantly improve or deteriorate in the future. By means of "future medical", the treator provides for treatment of "recurrent symptoms".

**Q: Does P & S have to occur before patient can have rehab?**

A: The patient can be declared a QIW and participate in vocational rehabilitation before reaching P&S status.

**Q: a) Do P & S reports of the Primary Treating Physician that are written by a "ghost writer" have to disclose who specifically wrote the report?**

A: Yes. But the PTP must review the report and should state the reasons why he/she concurs with the conclusions.

**b) Q: Can such a report be used to qualify as a Medical/Legal report?**

A: Only if specifically requested as such by an attorney or insurance company.

**Q: Under objective findings, are aspects such as ligamentors laxity, soft tissue edema/scarring, reproducible tenderness, etc., appropriate and or ratable?**

A: Scars, swelling, and edema are objective factors.

**Q: I am an orthopedic surgeon. When the treating doctor refers the patient to me for treatment of a knee injury like meniscus tear, I did the surgery & the follow up. When the patient reaches Permanent & Stationary status, who submits the P&S report? The treating doctor or me?**

A: The orthopedist has become the treating doctor as he performs the surgery and did follow up.

**Bernyce Peplowski, MD**

**Q: In the interest of maintaining quality of care, is it in your view appropriate for a physician to continue ordering physical therapy with vague orders to "assess and treat" if that physician lacks training in the use of physical therapy modalities?**

A: No, because the education process begins and continues with each order the physician writes if the physician solicits feedback and encourages communication with the therapist. If the physician orders a physical therapy assessment, the therapist should provide a report/summary so that the physician and

*Con't on p. 6*

◆ *Con't from p. 5 - Bernyce Peplowski*

therapist together can plan the treatment course. A site visit to the physical therapy office along with the ongoing communication will further enhance the physicians comfort level with this process.

**Q: What is the validity/authority of insurance company reviews with regards to workers' compensation?**

A: Beginning July 1, 1996, insurers were required to have in place a utilization review system. I refer you to CCR 9792.6, the Utilization Review Standard. Keep in mind that a utilization review opinion is not conclusive and does not override the treating physician's presumption of correctness. Recent case law (*Aleong vs. Golden Eagle*, April 16, 1998) ANA 30774 supports this. As the primary treating physician, we need to remember to be reasonable and clear, thus maintaining our presumption of correctness.

**Q: What is the proper protocol for a patient with severe subjective complaints and minimal objective findings. As the physician, you trust your patient is not inventing/exaggerating his symptoms?**

A: One way to control and decrease the patient's subjective complaints is to emphasize return to function. This is a good opportunity for a case conference between the therapist, physician and at times the employer/carrier. Physical therapy orders can re-emphasize reconditioning, exercises and/or work hardening. The return to work process can become a part of the rehabilitation program, with work tasks gradually increased. The patient's light duty/transitional work can actually become a part of the therapy.

**Q: Is physical therapy administered in/through the prescribing orthopedic surgeons office efficacious, and is it cost effective?**

A: Physical therapy through the physician's office offers the advantage of very close communication between the therapist and physician. Likewise, the physician can observe the patient's functional level during physical therapy. Potentially, this increased communication could reduce costs and hasten recovery.

**Q: As a primary treating physician, providing manual medicine and physical therapy, how often should primary treating physician take SOAPS (= E/M = \$)?**

A: As the primary treating physician, one is required to submit a progress note every forty five days. These visits include physical therapy. Reimbursement for primary treating physician progress notes is scheduled to begin in 1999. Even minus that reimbursement, it remains prudent (and in the patient's best interest) for the physician to provide a brief progress note (as in the IMC supplemental) at each office visit. Such a note is no more time consuming than a routine office progress note and provides valuable information to the claims administrator in regards to case progress. It also expedites provision of benefits to the patient.

**Q: Are hot packs for patients who live alone advisable?**

A: No. All patients benefit from a careful discussion of instructions, as well as risks/benefits, for any treatment (including hot and cold packs). Written as well as verbal instructions are advisable.

**Q: Can you tell us who did the study comparing physical medicine and E/M managed care that you related?**

A: Yes, Ernst and Young.

**Q: Managed care versus standard care PT statistical populations may not be the same.**

A: This challenge was acknowledged throughout the course of the study. The participating companies were provided the

option of treating with a managed care group or a preferred provider. Analysis of costs were made between study participants choosing managed care, participants choosing the preferred provider, and an independent control. As best possible, the study groups were matched for type of industry and size of employee population.

**Robert Larsen, MD**

**Q: When a doctor is in a grocery store and sees his patient doing something he said he couldn't do, how is that reported?**

A: I would not report anything of this nature to a third party. The physician's duty, whether a treating or evaluating physician, is not to be construed with an undercover investigator.

The patient has not given permission for disclosure of information that the physician comes across due to living in the same community as his/her patient. The patient has given permission for the physician to report on information that the patient knowingly discloses, and is observed by the physician in the office setting, which follows from diagnostic studies or comes as a result of information provided through records.

Rather than reporting observed behavior at odds with the patient's self-report that comes forth outside of the office setting, the physician would be better advised to discuss the matter directly with his/her patient.

**Q: My employer (an MD.) in his very modest shy manner, told. Don't ever write down "stress" as diagnosis!!! or I'll lose the client company!!! Write down "anxiety" or lumbar strain," etc. Please comment.**

A: It is certainly understandable that psychiatric diagnoses often times carry with them negative connotations. However, the non-specific descriptor of "stress" does not really convey much information to another party as the fact that the patient may be experiencing a psychiatric problem and is clearly not accurate.

Clinicians should strive to be reasonably accurate in the data reported without undue concern given to a client company's judgment of their clinical acumen.

**Q: What is the impact of the "Pettus" decisions on medical confidentiality and information disclosure?**

A: The case of *Pettus vs. Cole* did not directly involve a workers' compensation claim. However, legal experts differ as to their opinions concerning whether principles within *Pettus* apply to workers' compensation cases. In general, physicians should be careful about providing only relevant information.

The Confidentiality of Medical Information Act (CMIA) governs this area of medical practice. Physicians may wish to consult with their malpractice carriers concerning guidelines for reporting and when to obtain written informed consent for information disclosed.

**Mark Kahn, WCJ**

**Q: Does every workers' compensation case need a P & S at some point in time and if so, why?**

A: Workers' comp. permanent disability is an artificial concept for medicine. If you have a progressive disease like arteriosclerosis, as Dr. Markovitz told me once, the only P & S date is death. But in workers' comp. we have to end the case even though we know a condition is either going to get better or worse, so that is why there is a concept like P & S.

So, permanent & stationary becomes an artificial date where we say that we are going to end this case and give this person their permanent disability because they've stabilized to the point (at least for the next couple of weeks) they are going to be the same and even though we know, two years from now they are either going to be better or worse, they probably won't

*Con't on p. 7*

◆ *Con't from p. 6 - - Mark Khan*

stay the same. We have to end the case and that is the reason for a P & S date, otherwise these cases would just go on, I mean when will you end them?

And, so, it is an artificial concept to say we've ended the acute stage of treatment, we are now in the chronic, and we are going to rate them and whatever the future is, you have five years to reopen the case. If you get worse or better after that, it is "permanent" forever.

**Q: *Doesn't the IMC Physician's Guide state that percentage apportionment speculative and illegal?***

A: Percentage apportionment is perfectly legal as long as the physician has met all the other requirements of whatever code section you met. So, if you are under LC4750 and you have established there was a pre-existing disability and a basis for that disability then you either use the subtraction method or the percentage method. The subtraction is preferred and that is maybe why the *Physician's Guide* would use that, but the percentage method is there as long as you meet legal apportionment and you explain the basis why it is 50 - 50 or 60- 40.

**Ernest Levister, MD**

**Q: *How can the PTP convince the insurance carrier to authorize psychologic - psychiatric support which is needed for short term management of an injury ( or illness) - that this will not be a "stress claim" such that the carrier is buying every anxiety/depression reaction for the rest of the patient's life?***

A: The injured worker has the right to all reasonably required care to cure or for relief from the effects of his industrial injury or disease.

If you have a worker with a physical injury who develops mental problems [physical-mental] that substantially hinder the healing of the physical injury then the carrier has the responsibility to pay for the treatment of the mental problems until they abate.

If you have a worker with a physical injury that temporarily aggravates an underlying mental problem [physical-mental] that substantially interferes with the healing of the physical injury then the carrier has the responsibility to pay for treatment of the mental problem. This responsibility continues until the physical injury becomes permanent and stationary and the mental aspect return to its pre-injury level.

As the treating physician, you have a responsibility to provide optimal care to the injured worker. The Primary Treating Physician presumption of correctness combined with appropriate application of the Utilization Review Guidelines puts you in a pivotal position to treat the injured worker.

Under the Administrative Director's rules, you are required to file your treatment plan five days after initial contact with the worker. If you request in writing carrier authorization for treatment, you will trigger application of the Utilization Review Guidelines. The carrier, upon receipt of your request for authorization and supporting documentation, has seven work-

ing days to respond. Failure of the carrier to respond within the required time frame is tacit approval of your treatment plan.

You are not in a position to indicate or guarantee that the worker will not subsequently bring a separate workers' compensation case for mental disability and request for long term treatment.

**Phillip Wagner, MD**

**Q: *In an area where specialists are limited, how do you select them for your workers' compensation patients?***

A: In this area, we are fortunate to have fairly good specialty availability. Also, many of the specialists practicing in my area are QME certified, including an orthopedist and neurosurgeon, so that I have good choices. In smaller areas where the specialty choices are few or in which specialists failed to meet the requirements of the case managing physician, I would advise the physician to consider the following:

a. Obtaining a statewide QME list from the IMC and selecting a physician from that list for referral purposes.

b. Whenever there is the need for a specialty which is not available locally, I have frequently referred patients to the University of California or Stanford as an impartial center for evaluating their specialty problem.

**Q: *Is a P&S declaration made when maximum medical benefit is achieved or changes in conditions are "minimal" for a reasonable period of time?***

A: According to the Labor Code, P&S is declared when the changes in the patient's condition are minimal for a reasonable period of time. Maximum medical improvement is a specific phraseology utilized primarily in U. S. Department of Labor guidelines to describe permanent and stationary status.

**Q: *Please offer some practice software suggestions.***

A: The American College of Environmental Medicine offers a compendium of occupational health-related business software systems that compares the systems by various features that they have within them. I would recommend strongly reviewing that compendium initially and then asking for specific business software suggestions from the separate companies represented.

As I discussed in my lecture, I believe it will be important for every occupational health business and business professional to be able to document the efficacy found within their own office in terms of utilization review and to be able to integrate that into their actual practice. I believe it would also be essential that the software be able to deliver a module of information to an employer who contracts with the provider. Interconnectivity between the payer, provider and employer is the future of information transfer in Workers' Compensation.

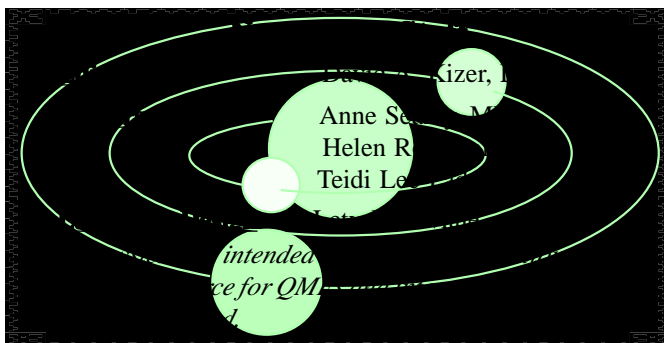
**Q: *How do you deal with farming industries who fire their pregnant female workers rather than deal with modified duty?***

A: This is a legal issue which most recently saw light at the State Supreme Court level. In a recent case it was determined that an employer who fires an employee for a disability can be subject to actions for wrongful termination. That finding has had a sobering effect on the attitudes of employers, and I believe you will see an improvement in this situation within the near future.

**Q: *Regarding primary treating physician, can an orthopedist remain a consultant even if surgery is performed?***

A: It is possible for an injured worker to have more than one treating physician in any given time. That physician who is primarily responsible for the medical management of that patient is designated as the primary treating physician. Other treating physicians may perform services for that patient up to and including surgical interventions and still be termed treating physicians.

*Con't on p. 8*





◆ *Con't from p. 7 - - Phillip Wagner*

**Q: Can a PTP refer his own QME? Can the insurance company dispute?**

A: A primary treating physician may not refer for a QME evaluation. The QME evaluation is only performed in cases where there are disputed issues in the case between the employer and the employee. Thus QME examinations are only utilized when medical legal issues exist. A primary treating physician may refer the injured worker in undisputed cases to another physician to construct the primary treating physician's Final Comprehensive Report.

**Q: Does an employer have the responsibility of allowing the injured worker to leave work to obtain treatment?**

A: This is a gray area in the labor code, and in practice has many variations. I have seen company policies that varied from no time off work allowed for treatment to full pay while the patient is receiving active medical treatment. I have not found a statute, however, which requires the employer to allow the injured worker to leave work to obtain treatment.

**Q: Regarding other individuals as primary treating physicians, can the employer utilize nurse practitioners who have not provided regular medical care for the employee by having employees pre-designate these individuals after hire?**

A: As provided in the Labor Code 4600, the employee may select their personal physician as a pre-designated physician to utilize in case they are injured at the work site. The requirements within the Business and Professions Code dictate that this physician has "previously directed the medical treatment of the employee and who retains the employee's medical records, including his or her medical history".

Thus, I think the description rendered in your question would be an inappropriate use of designation by an employee. However, in the first 30 days after an injury, if an employee has not designated a personal physician, the employer may choose a physician of his choice to render services to that employee for the first 30 days following the injury or illness. Thus in a case where the employer is selecting the treating physician, they have the right to select a physician who may not have seen the employee previously for medical treatment. Nurse practitioners may be utilized under the current labor code as long as they are under the direct supervision of a physician as defined in the Labor Code.

**Q: What is the name of your software? Where can we locate this application?**

A: I believe the software that you are referring to in this question has to do with in-office utilization review and practice protocols. I must confess a conflict of interest in this question, as I am one of the principals of the only company I am aware of with prospective practice protocol software. This is called Compró. It is available through Electronic Medical Consultants, 865 Via de la Plaza #202, Pacific Palisades, CA 90272.

**Q: Many of the insurance companies do not want to recognize MO102-92 allowing 80% of med-legal fees for the PTP final report if the report addresses all of the issues, etc. We have been filing liens. The carrier's usual argument is that they did not request a med-legal report. What is our position? What legal code or laws support the PTP's position? Shouldn't all appropriate PTP prepared final reports be billed as MO102, whether specifically requested or not?**

A: The primary treating physician is not allowed to make charges on the medical-legal fee schedule unless we are responding to a request for information on a disputed issue. If there are no disputed issues in the case, the medical-legal fee schedule may not be used.

There has been significant confusion and consternation over the appropriate methods of charging for Primary Treater's Final Comprehensive Reports and what constitutes a Final Comprehensive Report. In the advance version of the new Official Medical Fee Schedule, there is a provision for reimbursement of the primary treater's final report with and without residual impairment. Where no residual impairment exists, the primary treater's report is a single page which in fact indicates that there is no residual impairment and no additional medical treatment will be required, and that the patient is discharged as cured.

This will be charged out on a 99080 basis. Where residual impairment exists, the Primary Treater's Final Comprehensive Report must be comprehensive and include all of the items as specified previously in Question #5. The method for charging for that report is outlined in the Official Medical Fee Schedule Report Guidelines. Specifically, it is appropriate to charge an office visit for the time spent with the individual in evaluation. This would be either a 99215 or a 99205 visit, depending on whether or not the patient had been seen previous to this evaluation. Secondly, it is appropriate to charge for generation of a report under a 99080 as outlined in the fee schedule. This allows you to charge a specific

## The 1999 IMC Officers

**Dr. Richard Pitts and Dr. Steven Nagelberg - Co-Chairs,**  
**Dr. Lawrence Tain - Vice-Chair**  
**Dr. Glenn Repko - Secretary**

amount for the first six pages of the report. Thirdly, it is appropriate to charge a 99358 or a 99359 for time spent in records review in compiling the report. The sum total of these charges will vary according to the amount of time you have spent in reviewing the records prior to preparing the report. It will range from \$320 to \$400, depending on the time put in. I have personally prepared over 400 of these reports, and this formula has been deemed appropriate by most insurance companies and payment has been made.

**Q: Is the time period for record review compensable when preparing PTP reports?**

A: The answer is yes, and it is under Section 99358 on the advance copy of the new Official Medical Fee Schedule. This is broken down into 15 minute segments of non-face to face time in reviewing reports. It should be charged out accordingly.

**Q: Where did you find a format for the Final Comprehensive Report?**

A: I believe an appropriate format for that report will be found in my lecture notes from the conference, basically touching on each of the items mentioned in that section. I developed this after reviewing the requirements as set forth in the Treating Physician's Determination of Medical Issues, Form #81556, promulgated by the IMC.

**Q: If they do, what should the PTP do with the patient if the primary treating physician believes that the MRI must be performed before further treatment is appropriate? The same question with surgery, etc. Should he then make the patient permanent and stationary at the present level of disability, assuming that no further diagnostic studies are being authorized?**

A: This is an excellent question. The practice of occupational medicine for purposes of utilization review has now been placed back on the medical playing field. If there is denial of authorization for any requested service, utilization review regulations established under Section 9792.6 of Title VIII of the California Code of Regulations sets the

*Con't on p. 9*



◆ *Con't from p. 8 - - Phillip Wagner*

ground rules.

If the primary treating physician is unable to establish satisfactory medical criteria to convince the carrier that authorization is appropriate, the carrier must run this by a physician with equal qualifications to the treating physician requesting the service. If that physician decides against authorization, there is usually an appeal process within the company that allows for a board to hear the appeal. If that appeals process fails and the primary treating physician is still convinced that this treatment is necessary, it is possible for the patient to file a Declaration of Readiness to proceed and take it in front of the judge for a ruling, so there are at least three levels of action available to the primary treating physician. If, in the end the primary treating physician is unable to establish sufficient medical criteria to obtain authorization for that treatment or diagnostic procedure, I believe it would be prudent to make the patient permanent and stationary, write a final compensation report, and indicate that future medical treatment may be required, indicating specifically what tests and procedures you think are appropriate.

***Q: Clarify the difference between discharged as cured and P&S. Which is compensable? Is there a report needed at the end of each injury?***

A: Permanent and stationary status occurs when the patient has residual impairment and their medical condition has not changed significantly over a "reasonable period of time". The term permanent and stationary implies residual impairment and requires a comprehensive Primary Treater's Final Report. Discharged as cured indicates that the patient has no residual impairment at the conclusion of their treatment for their work-related injury. In this case, a brief Primary Treater's Final Report is sufficient to indicate that no residual impairment exists. Both these reports are compensable under the advance copy of the new Official Medical Fee Schedule.

***Q: If abnormal findings are detected on a pre-employment work up, for example, if an ortho surgery or a chest x-ray mass is detected, to what extent is the employer financially responsible for further evaluation?***

A: With the new employment law it is my understanding that an employee is offered a position prior to the physical examination being performed. The physical examination (called pre-placement) must determine whether or not the employee is fit to perform the duties of the position that has been offered to that employee. It would seem to me in this case that the employer would need to provide sufficient medical evaluation to make a determination as to whether or not this person is appropriate for employment and that no further treatment or evaluation would be required.

***Q: You advise QIW status as soon as it is apparent that the injured employee would not be able to return to usual and customary occupation. However, I have stopped doing this as I have never seen anything done until P&S status is rendered, and have been advised by one local carrier that they cannot do anything until P&S is reached. Comments?***

A: The primary treating physician is invested with the authority to determine issues of compensability. One of these is Qualified Injured Worker status. Another is Permanent and Stationary status. Another is Issues Arising Out of Employment. These conditions of compensability can be determined at any time during the case, and are not dependent on any other condition pre-existing them.

Therefore, once it is determined that an injured worker has sustained sufficient injury to prevent them from returning to their regular occupation as appropriate to initiate the vocational rehabilitation service, that patient may remain on tem-

porary disability in terms of indemnity issues while the initial stages of vocational rehabilitation are being instituted. This is not only allowed, but encouraged by the policies of the Industrial Medical Council. I would refer you to the Manual for the Treating Physician promulgated by the Industrial Medical Council for reference.

If the carrier is refusing to initiate the process of vocational rehabilitation promptly, the patient may independently petition to have a qualified vocational rehabilitation counselor assigned to this case through the WCAB.

***Q: Should you treat on lien?***

A: The treating physician has authority to determine issues surrounding Arising Out of Employment questions. Therefore, it is the duty of the primary treating physician to listen carefully to all evidence before rendering an opinion as to whether or not this represents a workers' compensation injury.

If the primary treating physician, after hearing all appropriate evidence, believes that this case is compensable, they can proceed to treat on a lien basis by filing a lien with WCAB. Personally, I do treat on liens occasionally, but I am careful to indicate to the patient that should the case be determined to be noncompensable under workers' compensation that they will be responsible for the charges generated in the course of treatment.

**David Kizer, Esq.**

***Q: Is drug testing legal for employees in California?***

A: For most occupations, random drug testing of employees in California is illegal. Under certain circumstances, "suspicion based" drug testing may be done but the courts apply a "balancing test" to weigh the employee's expectation of privacy under the California Constitution against the employer's right to know whether an employee is using illegal drugs on the job. There are also strict parameters set on how the testing is to take place.

***Q: Does a positive result void an employee's benefits?***

A: Not necessarily. It depends on the drug involved, the circumstances and whether, in the physician's opinion the employee's perception/motor skills were impaired. Of course, a proper foundation must be laid for the Judge who will determine whether causation is satisfied and benefits should be denied. For example, if an employee is drunk on the job and, due to the negligence of a co-employee, a two-by-four falls and strikes him on the head the defense of intoxication won't work. The employer has the burden of proof in these cases.

***Q: Can a Primary Treating Physician designate another physician to write the final report if it is disclosed and the PTP states that he has read the report and agrees with it?***

A: Under current law, this is acceptable. It would be wise for the PTP to review the report carefully and provide a cover sheet explaining why the report is consistent with the treater's opinion.

***Q: What is the confidentiality of a patient's records when they have a work injury but also have old or unrelated injuries with the treater as their (family) personal physician?***

A: Generally, all medical reports which contain treatment or references to injuries and conditions can be made available to the carrier through a subpoena during discovery. If there are records that the patient feels are unrelated to the claim, it is his responsibility to file the appropriate motion with the Appeals Board to deny access to the records ("quashing a subpoena").

***Q: Why are lawyers paid from an injured worker's permanent disability award?***

A: Attorneys are prohibited by law from accepting direct pay-  
***Con't on p. 12***

## ◆ *Con't from p. 1 - IMC address*

❖ Regarding the electronic submission of claims which is what most insurance industries are doing now, they hope that the IMC could participate, urging the carriers to allow doctors to do electronic submission of claims.

❖ The COA urged that a study be put together by the IMC on the issue of Labor Code Section 5307.6 which deals with studying AME and QME payment schedules. Are they really reimbursing comparable to what is done in other areas of medical legal evaluation in California?

### ***Jim Hester, President of the California Workers' Compensation Defense Attorneys' Association (CWCDA):***

❖ The IMC needs to take a stand against the Treating Doctor Presumption as presently set up in the Labor Code and let the legislatures know that it is not working. The Treating Doctor Presumption fosters litigation and makes the treating doctor's choice a tactical decision rather than a medical decision. It needs to be seriously reworked.

❖ The treatment protocols need to be tightened up. The IMC needs to make the treatment protocols more forceful and needs to establish at least a presumption in favor of the treatment protocols. The IMC needs to make sure that the protocols are fair to both the workers and employers.

❖ The Panel QME referrals for unrepresented applicants need to be scrutinized for fairness. The Panel QME referrals are being made to doctors and chiropractors who are perceived as being applicant oriented or defense oriented. A system should be put in place to ensure that Panel QME referrals are made to unbiased QMEs who are quality physicians.

### ***Vern Goldschmidt of the California Applicants' Attorneys Association (CAAA):***

❖ The CAAA would like to see the IMC continue to educate and qualify QMEs, to continue to send out panel letters to unrepresented workers and to continue with discipline of QMEs, because they think that the IMC is doing a very good job in this particular arena. The CAAA thinks that if the legislature or the executive branch asks the IMC to study in a certain area, that certainly is where the IMC should be going, but the CAAA does not favor a proactive agenda for IMC.

### ***Dr. Gideon Letz, Medical Director, State Compensation Insurance Fund (SCIF):***

❖ The IMC ought to look at managed care in workers' comp. particularly as it relates to physicians profiling and case mix adjusting for the workers' comp. system. This area is breaking new ground across the country and very problematic. The more that physicians get involved in setting standards and methodology for those processes, the better off the system would be.

❖ In the area of technology assessment, like new treatment modalities, exciting things are going on particularly in orthopedics and other areas critical to workers' comp. These procedures have real potential to benefit injured workers on one hand. On the other hand whenever there is a new procedure coming out, there is a tendency to jump in and do it. The IMC should undertake technology assessment, as new technologies are developed as one of its on going functions.

❖ There is a tremendous need for objective measures for functional capacity for injured workers and how they get back into the job situation. The study that the IMC funded with Drs. Mooney and Mathison needs to be revisited and followed up.

❖ There are some specific things that are problematic for payers such as how we define first aid and blood borne pathogen management. These are things that the IMC, with all its

medical expertise, could create, such as guidelines for the community, and how to use them.

❖ There are exciting things going on the area of disability management and the IMC could do some follow up on its initial policy statement and start exploring what is going on and maybe come up with some suggested guidelines that go beyond just stating that what you believe is important.

### ***Carl Brakensiek of California Society of Industrial Medicine and Surgery (CSIMS):***

❖ One of their major concerns was the graying of the QME pool. CSIMS feels that it is important that one of the duties of the IMC is to ensure that we have a healthy and stable or growing pool of QMEs who are competent and are available to evaluate injured workers.

❖ CSIMS is concerned that the way the system presently exists, there are barriers to entry to becoming a QME. You should not be able to become a QME unless you've written some reports, gain the experience and learn the rules and regulations. They suggest that the IMC recognize that the current system that we have for creating and appointing QMEs, the standards for QMEs was the result of negotiations in 1989 and again in 1993 by lobbyists who went to Sacramento representing different interest groups. The system represents the combined

input from all these groups that led to the rules that we have now for QMEs.

❖ The IMC should look at some of the continuing education requirements. Specifically, are they too stringent, or are they not sufficiently demanding on providers to ensure that they give good quality courses? The IMC should look at and

take actions on some of the disincentives to being a QME in the system. What should be done to reduce the cumbersome rules? What about the mind boggling ground rules under the fee schedules? What about all the paper work that doctors have in the system? What about the dilatory practices of some payers that make it a substantial disincentive to physicians to treat and evaluate injured workers?

❖ The second area is that of occupational safety. Each of the council members has a great deal of expertise in this area and he urged the Council to work with Cal OSHA, CHSWC and with other state organizations in developing serious programs to enhance workplace safety to see what we can do to prevent injuries from happening in the first place.

❖ The IMC should consider becoming more activist. There are things in the statutes that are not in the best interest of the injured workers, for example the 51% threshold for mental injuries, which was a political issue that was jammed through in 1993, and he asked the IMC to look at this again and perhaps make some recommendations that the legislature fix the problem.

### ***Ms. Kenlyn Boyd, Applied Risk Management:***

The IMC should look for a way to help payers in a proactive method in reviewing QME reports that are complex and consists of stacks of pages. Help them to adjust the costs associated with it and perhaps teach them as well. If the IMC can put this into a long range plan, it would certainly help the payer's community.

### ***Dr. Dean Falltrick, Life Chiropractic College West:***

Life West is interested in working closely with the IMC in some of the long range planning, particularly, issues that would involve their research department, to do research other than a proprietary or chiropractic oriented format.

***Con't on p.11***

***Reminder to QMEs - Don't forget to include a birth certificate or proof of citizenship when you apply or renew your QME term.***

◆ *Con't from p. 10 - IMC Address*

**Ms. Benita Gagne, Inter Community Medical Group:**

New doctors who are interested in getting involved in the workers' comp. system by becoming QMEs and really do not understand how the system works, should be encouraged to take some training in report creation and disability evaluation in order to qualify for the QME certificates.

**Dr. Susan McKenzie, Associate Medical Director, IMC:**

Dr. McKenzie directed her comment to the Relative Values Scale (RVS) of the fee schedules. The RVS sets the values of each of the services in the fee schedules. There has been no written records that document where these values came from therefore, the scale contains a lot of aberrant relationships among values and some of these bear no relationship with the current technology and may not reflect the true market value in providing that service. She said that it is very important that the IMC do a study which looks at alternatives to the current RVS.

During the July 1996 meeting, it was decided to look at the alternatives that were available for use in California and particularly to look at the resource based scales that based their values on the cost of providing medical service. What the IMC is proposing this time is to fund an educational study that will allow us to look at all the alternatives that are available for use in California. There are a number of proprietary scales, the RBRVS and the Department of Labor scale which has modified the RBRVS. The IMC's intent would be to look at all those alternatives so that we will have a common knowledge base with which to approach the problems.

Dr. McKenzie assumed that the IMC will be able to find someone to do the study. This would allow the IMC to look at the Relative Value Scales and try to evaluate if there are better alternatives for use in California.

**Dr. Michael Roback, IMC Council member:**

Since the IMC has some funds, the IMC could become an educational center. He suggested that the IMC consider establishing a library function at the IMC as a central information source. Potentially, the Council Members might want to individually choose to become involved with certain subjects. Once this is established, the newsletter can be expanded to become a news journal.

In regards to the Neuromusculoskeletal Committee, the Council should look again at examination techniques specific to the neuromusculoskeletal system. He summed up by saying that the IMC can become the center of knowledge for the health care providers in the California Workers' Compensation System.

**Ms. Patsi Sinnott P.T. M.P.H., IMC Council member:**

❖ The IMC should look into establishing a research agenda among the Council Members;

❖ The IMC should make sure that there are enough QMEs in the system. The IMC should be able to see where the demands for evaluations and panels occur. Were they used by different parties? The IMC could do recruitment or education in order to bring more providers into the system especially in those areas that have unmet demands.

**Brian C. Fennen, L.Ac., President of the Council of Acupuncture and Oriental Medicine Associations (CAOMA):**

❖ They are requesting representation on the IMC, by legislation with the support of IMC, for a licensed acupuncturist to be appointed to the IMC;

❖ They request that the IMC consider the option of allowing acupuncture QMEs with specified additional training to per-

form disability evaluations. They are also requesting the IMC's assistance in establishing standards for acupuncturist performing disability evaluation and appropriate educational standards that schools can implement. The schools would then produce graduates with the necessary competencies to become mainstream providers for injured workers.

**Dr. Paul E. Wakim, Osteopathic Physicians State of California (OPSC); IMC Council member**

❖ The OMT code should be maintained under the physical medicine section of the OMFS;

❖ The OMT and E/M codes should be reimbursed according to the treatment provided at the time, which means that Osteopathic physicians in the State don't do an E/M billing without an evaluation and actual treatment and they do not do OMT on a contracted basis. The E/M and OMT payments should be reimbursed separately and if done at the same time should both be reimbursed.

**Dr. Robert Goldberg M.D., IMC Council member:**

❖ Dr. Goldberg thought that the Council should be doing outcome research on the treatment guidelines. Also, since they were consensus based and not necessarily best practices, it was incumbent on the Council to validate the guidelines.

❖ His second point was that the IMC should strive for quality assurance enhancement of QME reporting. This has been repeated again and again at today's meeting. Dr. Allan MacKenzie said that the only way to improve the quality of the QME reports is to do more Tier Two and Tier Three filters on the reports being submitted.

◆ *Con't from p. 4 - Patient*

to understand the many factors that can influence the injured workers and your interpretation of their pain. For example, an isolated positive flip test is meaningless unless taken into context of the total presentation of the injured workers history and examination.

We will first deal with a variety of issues that can influence the physicians interpretation of symptoms. In other words, how does this presentation affect the physicians' believability of the patient. We will then look at using the patients' believability factors in applying subjective factors of disability.

The history of the injury, response to treatment, score on outcome assessments, time off work and various factors in the physical exam can all affect patient believability. This is certainly not an inclusive list but serves as a starting point.

**History of Injury:**

Obviously, most physicians are aware of patients that have a minor injury such as picking up a ream of paper and six months later they are still undergoing treatment for a back strain with complaints of severe pain, limited mobility and are unable to do all but the lightest of activities. This should be one of the easier 'red flags' to identify that an injured worker's believability may be suspect. Everyone has a different response to pain however, it is important to determine if this would be a credible response.

**Response to Treatment:**

I find this to be one of the most telling signs. If someone has had a minor back strain and had six months of physical treatments including physical therapy, chiropractic care, and temporary disability and they report no improvement of their symptoms, in my book this is a red flag. We all know that most injured workers will achieve some degree of symptom

*Con't on p. 12*



◆ *Con't from p. 9 - - David Kizer*

ment from an injured worker for services rendered. There is a statute which provides for attorney fees to be paid from the injured worker's award or settlement (LC § 4903).

***Q: Must a person claim a psyche injury to receive treatment for depression stemming from an orthopedic injury?***

**A:** Generally, an injured worker must have a separate claim form for each separate injury. Often, as in your example, a physician determines that there is a psyche overlay to an orthopedic injury (two claims occurring from one injury with the claim form only listing the first injury). In these cases, the carrier should immediately authorize treatment if the physician determines that it is work related. If there is a dispute, the injured worker should consult with an attorney or the Information and Assistance Officer at the local board to file an amended claim for the psyche injury and start the formal 90 day investigation period for the carrier again.

◆ *Con't from p. 11 - - Patient*

relief over that period of time without any treatment. This injured worker should not be confused with one who has achieved a fair degree of symptoms relief but has had multiple flare-ups. Multiple flare-ups, especially right before it is time to return to work, may be a red flag. This is quite different than someone who reports that no treatment has helped them or that they just continue to get worse.

**Outcome Assessments:**

There are many outcome assessments that can be used to

measure patient response to treatment. A classic example for the low back is the Oswestry's, Roland Morris and visual analog scale. There are outcome assessments for most every body part. While the physician doing the med/legal evaluation may only be seeing the patient once these tools can often provide valuable information. An example would be; someone had a minor back strain and six months later still scores an 80% on the Oswestry. This score is rarely compatible with that type of injury. Additionally, you will find that many of the questions they answer are based on their interpretation on what would happen if they tried the activity, not if they did it themselves.

An example: the patient says they can only do light lifting. Usually when you question them they have not tried any heavy lifting. They must assume if they do it then they will have pain. If the evaluating physician starts having the patient fill out these tools and compares those with the believability factor they can gauge some important information.

**Time Off Work:**

Someone who has had extended periods of disability, whether consecutively or aggregate for a minor injury may be suspect. The same thing may be said for the injured worker that refuses to try to go back to work. This is an area we have to tread carefully. Patients do know their own bodies and sometimes they may have a legitimate concern in their own mind that they may re-injure themselves if they go back to work. This may or may not be validated by whatever objective findings/factors of disability are present. One must compare the examination findings as we will discuss later and the worker's concerns and determine if it is believable.

*Part II will be in the next issue.*

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